



Final CY 2022 PHYSICIAN FEE SCHEDULE

FACT SHEET | November 2021

The Center for Medicare and Medicaid Services (CMS) released their final Physician Fee Schedule (PFS) for CY 2022. The PFS are the policies that the agency will be implementing for Medicare beginning on January 1, 2022, unless otherwise noted. This is the typical vehicle utilized by CMS to make administrative changes to telehealth policy in the Medicare program. After receiving and addressing public comments, CMS has decided to finalize the following:

▶ TELEHEALTH SERVICES

CMS adds services that are eligible to be reimbursed when provided via telehealth if they pass one of two tests:

Category 1 – Where the service is essentially similar to a service already on the eligible list.

Category 2 – If the service is not similar to one already on the eligible list, there is evidence that demonstrates clinical benefit to the patient if it is provided via telehealth.

During the COVID-19 public health emergency (PHE), CMS made available for reimbursement certain services if delivered via telehealth. These services were placed on a temporary eligible list for telehealth delivered services as

long as the federal PHE lasted. In the PFS for 2021, CMS created a Category 3 which would act as a temporary holding category for some (but not all) of the services that were placed on the temporary COVID-19 eligible services list. Under the 2022 PFS, CMS is finalizing details that would allow the services in Category 3 to remain eligible for delivery via telehealth and reimbursed until the end of CY 2023. Additionally, CMS is adding the following codes to Category 3:

- **93797** – Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)

- **93798** – Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)
- **G0422** – Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise (per session)
- **G0423** – Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise (per session)

▶ CONSOLIDATED APPROPRIATIONS ACT

The Consolidated Appropriations Act (CAA) passed in December 2020. It made certain changes to permanent telehealth policy (permanent telehealth policy is hereafter referred to “Original Telehealth Policy”). Original Telehealth Policy are the telehealth policies that will revert back into effect or remain after the PHE is declared over. Among those changes passed in the CAA were removing the geographic limitation when providing mental health services and allowing the home to be an eligible originating site for such services. However, a caveat was included that stated for the exception to the geographic limitation and allowing the home as an eligible originating site for these services to occur, the telehealth provider must have had an in-person interaction with the patient within six months prior to the use of telehealth. This in-person requirement does not apply to cases that would be eligible outside of what was required by the CAA. For example, if you were receiving services via telehealth in a doctor’s office that would qualify under the rural restriction, the prior in-person visit with the telehealth provider need not have taken place. In addition, it does not apply when a patient is being treated for substance use disorder with co-occurring mental health disorder, since previously existing statute provides an exception in those circumstances from the geographic requirement and

allows the home as an eligible site. It was left up to CMS to decide if and how often subsequent in-person visits are needed. In the proposed 2022 PFS, CMS had inquired whether the six-month in-person visit requirement needs to occur within six-months before each telehealth service and whether the provider who furnishes the in-person visit needs to be the telehealth provider or if it could be another provider in the same specialty and in the same group.

CMS finalized policy includes:

- ✓ Clarification that the six-month prior in-person visit must be the furnishing of an item or service for which Medicare payment was made in order to meet the six-month in-person requirement. Therefore, if Medicare payment was not made for that visit, it would not meet the necessary six-month in-person visit.
- ✓ Subsequent requirements for an in-person visit must take place 12 months prior to the telehealth services and there are some narrow exceptions such as when the patient and provider agree the risks and burdens of an in-person visit are outweighed by continuing via telehealth, such as possible disruptions. However, this must be documented in the medical record as well as documenting that the patient is able to obtain needed point of care testing, including vital sign monitoring and laboratory studies.
- ✓ A colleague in the same subspecialty and same group may furnish the in-person visit if the telehealth provider is not available to meet the in-person visit requirement.
- ✓ “Home” may be defined to include temporary lodging (hotels, homeless shelters) and if the patient chooses to travel a short distance from the exact home location.

Also under the CAA, rural emergency hospitals are added to eligible originating sites for telehealth. CMS will make this change beginning in CY 2023.



▶ AUDIO-ONLY

CMS finalized their proposal to allow audio-only to be used as a delivery modality for the treatment, evaluation and diagnosis of mental health. CMS was able to enact this policy based upon a redefinition for “telecommunications systems.” The term “telecommunications system” is not defined in federal statute. CMS in regulations added the word “interactive” to “telecommunications system.” However, certain conditions will need to be met in order to make delivery of mental health services eligible for reimbursement in Medicare. These conditions are:

- ✓ It is for an established patient
- ✓ The home is the eligible originating site
- ✓ There must have been a six-month in-person item or service provided, a 12-month subsequent in-person visit
- ✓ Provider has capability to provide live video but is utilizing audio-only because patient chose or cannot use live video

A service level modifier will be created for these visits and the provider will need to document in the patient record why audio-only was used (language for this is being finalized by CMS).

▶ FQHCs/RHCs

Federally qualified health centers (FQHCs) and Rural Health Clinics (RHCs) may only act as originating sites under Original Telehealth Policy. A temporary exception was made for the PHE to allow them to be distant site providers, but the permanent policy as of now, November 5, 2021, remains unchanged. Under the CY 2022 PFS, CMS redefines what a mental health visit is for an FQHC and an RHC. The new definition for a **mental** health visit for an FQHC and RHC will also include encounters furnished through interactive, real-time

telecommunications technology when furnishing services for the purposes of diagnosis, evaluation, or treatment of a mental health disorder. Additionally, to align with the aforementioned provision of mental health services via audio-only, FQHCs and RHCs are eligible to provide mental health services via audio-only when the patient is not capable of or does not want to use live video. For these services, FQHCs and RHCs will be required to use the 95 modifier (for live video interactions) and a new service modifier will be created for audio-only. FQHCs and RHCs will also be subject to the same six-month in-person visit and subsequent 12 month in-person visit requirements that were required by the CAA, though limited exceptions are made for the 12 month in-person visit. This in-person visit is only required if the patient is receiving services in the home.

RHCs are paid an all-inclusive rate (AIR) and FQHCs are paid a prospective payment system (PPS) rate. During the PHE, RHCs and FQHCs were allowed to act as distant site providers but did not receive their typical AIR or PPS rates. Instead, under federal law, a methodology was created to determine one flat rate, regardless of the service. For CY 2021 that rate is \$99.45. This rate and methodology employed was only meant to apply for services provided during the COVID-19 PHE. Therefore, for the above mental health services, FQHCs and RHCs would receive their usual PPS or AIR rates. However, as FQHCs and RHCs are not allowed to provide services via telehealth, the reporting for these services will be different.

FQHCs and RHCs will also be allowed to bill for Transitional Care Management (TCM) and other care management services furnished “for the same beneficiary during the same service period provided all requirements for billing each code are met. This would include the services described by HCPCS codes G0511 (General Care Management for RHCs and FQHCs only) and G0512 (Psychiatric CoCM code for RHCs and QHCs only), which both describe a service period of one calendar month.”

► COMMUNICATIONS TECHNOLOGY BASED SERVICES (CTBS)

Communications Technology Based Services (CTBS) are services that utilize telehealth technology to deliver the service, however, unlike telehealth, there is no comparable in-person service for them. CMS regards telehealth delivered service as a direct replacement for a type of service that would typically take place in-person. For example, a regular office visit to your primary care provider can be done via telehealth. With CTBS, technology has enabled the provision of services that normally would not take place in-person. For example, multiple blood pressure readings for a hypertensive patient taken over a period of time. While a remote blood pressure monitor can take these readings and electronically transmit them to a provider, a patient is not going to see a provider multiple times a day to have their blood pressure read over a consecutive period of days. Therefore, CTBS is not regarded as “telehealth” by CMS in Medicare and are not subject to the policies seen in Original Telehealth Policy, though CMS has created their own policies that apply to these services. CMS finalized the following CTBS service for CY 2022:

- **G2252** will be made permanent. G2252 is defined as a brief communication technology-based service, virtual check-in service, by physician or other qualified health care professional who can report E/M services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment, 11-20 minutes of medical discussion – finalized and allow. There is a direct crosswalk with CPT Code 99442.

REMOTE THERAPEUTIC MONITORING (RTM)

Remote Therapeutic Monitoring (RTM) codes are similar to remote physiological monitoring codes (RPM). However, RTM primary billers are meant to be psychiatrists, nurse practitioners (NPs), and physical therapists (PTs). RTM allows for non-physiological data to be collected which also differs from RPM. CMS had expressed concerns that certain therapists would not be able to bill for these services. However, CMS believes the services described by the codes are important to beneficiaries and are finalizing a policy that “permits therapists and other qualified healthcare professionals to bill the RTM codes as described. However, where the practitioner’s Medicare benefit does not include services furnished incident to their professional services, the items and services described by these codes must be furnished directly by the billing practitioner or, in the case of a PT or OT, by a therapy assistant under the PT’s or OT’s supervision.” The RTM codes are:

- **98975** – Remote therapeutic monitoring initial set up and patient education on use of equipment.
- **98976** – Remote therapeutic monitoring with device(s) supply with scheduled recording(s) and/or programmed alert(s) transmission(s) to monitor respiratory system, each 30 days.
- **98977** - Remote therapeutic monitoring with device(s) supply with scheduled recording(s) and/or programmed alert(s) transmission(s) to monitor musculoskeletal system, each 30 days).
- **98980** – Remote therapeutic monitoring treatment management services physician/ other qualified health professional’s time in a calendar month requiring at least one interactive communication with the patient/caregiver in a calendar month, first 20 minutes.



- **98981** - Remote therapeutic monitoring treatment management services physician/other qualified health professional’s time in a calendar month requiring at least one interactive communication with the patient/caregiver in a calendar month, each additional 20 minutes.

CMS is finalizing five codes for Principal Care Management (PCM) and Chronic Care Management (CCM). These codes are:

- **99437** – CCM service each additional 30 minutes by a physician or other qualified health care professional, per calendar month.
- **99424** – PCM services for a single high-risk disease first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.
- **99425** – PCM services for a single high-risk disease each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.
- **99426** – PCM for a single high-risk disease first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.
- **99427** – PCM for a single high-risk disease each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

G2080. After the PHE, OTPs will need to document audio-only was used in patient medical record along with a modifier. The latter requirement would apply to services taking place after PHE.

- ✓ During the PHE, CMS allowed for certain in-person supervision requirements or the availability of the supervisor in-person to be provided virtually through telehealth. After soliciting comments, CMS has decided that it will consider addressing the concerns raised in future rules or guidance.
- ✓ Originating site facility fee will be \$27.59.
- ✓ CMS is allowing for inclusion of 99441, 99442 and 99443 in the definition of primary care services used for beneficiary assignment until no longer payable under the physician fee schedule fee for service payment policies under the Shared Savings program for ACOs.
- ✓ CMS declines to add telephone codes 99441-99443 as permanent services that will be reimbursed.
- ✓ Medical nutrition therapy (MNT) and diabetes self-management training (DSMT) services may be provided as telehealth services when registered dietitians or nutrition professionals act as distant site practitioners.

▶ ANALYSIS

Most of the telehealth proposals CMS made in July 2021 for CY 2022 remained though there were some changes and clarifications.

For the required prior in-person visit for mental health services where the Original Telehealth Policy of geographic limitation would not apply and allowing the services to take place in the home, that in-person visit would need to take place:

▶ ADDITIONAL POLICIES

- ✓ Allow Opioid Treatment Programs (OTPs) to use audio-only to furnish therapy and counseling when live video is not available to beneficiary after the PHE is over. Modifier 95 will need to be used to claim the counseling and therapy add on code

- ✓ At least six-months prior to the services being delivered via telehealth live video or audio-only and that in-person visit must be for an item or service that was reimbursed by Medicare.
- ✓ Subsequently, the in-person visit can occur 12 months before the telehealth visit, though exceptions will be made in very limited circumstances such as when the provider and patient decide the benefit of having the in-person visit is outweighed by continuing via telehealth. For example, treatment possibly being disrupted due to the patient to make an in-person visit.
- ✓ Home was also defined as including other locations such as temporary lodging and even locations a short distance from what is regard as “home”.

Additionally, the six-month in-person visit (and subsequently 12 month in-person visit requirement) will also apply to delivery of mental health services through audio-only services. Note that the initial 6-month in-person visit and 12-month subsequent in-person visit rule does not apply to non-mental health visits, however they must still qualify under Medicare’s geographic and originating site restrictions to qualify for reimbursement.

CMS will be allowing live video and audio-only to be a modality in which FQHCs and RHCs may deliver mental health services if certain parameters are met. They will receive their PPS/AIR rates. These services will also be subject to the six-month in-person/12 month in-person visit requirement as well if services take place in the home. These services are not considered to be telehealth, as FQHCs and RHCs are not eligible to provide services via telehealth in the Medicare program. Therefore, presumably FQHCs and RHCs will not face the same limitations other providers face utilizing telehealth such as geographical limitations because under this proposal, they are not regarded as telehealth. They are merely visits.

Several other items to note, there was also a heavy requirement to use modifiers, likely to help CMS identify the amount of services taking place through a certain modality. While in several places CMS stated it will be coming out with a new modifier, the American Medical Association (AMA) has also been working on a modifier for audio-only. There were more documentation requirements on why services were delivered through a certain modality such as OTPs documenting when audio-only was used. Additionally, the 6 month/12 month in-person visit prior requirement appears when services are taking place in the home.

Subsequently, the in-person visit can occur 12 months before the telehealth visit, though exceptions will be made in very limited circumstances such as when the provider and patient decide the benefit of having the in-person visit is outweighed by continuing via telehealth.

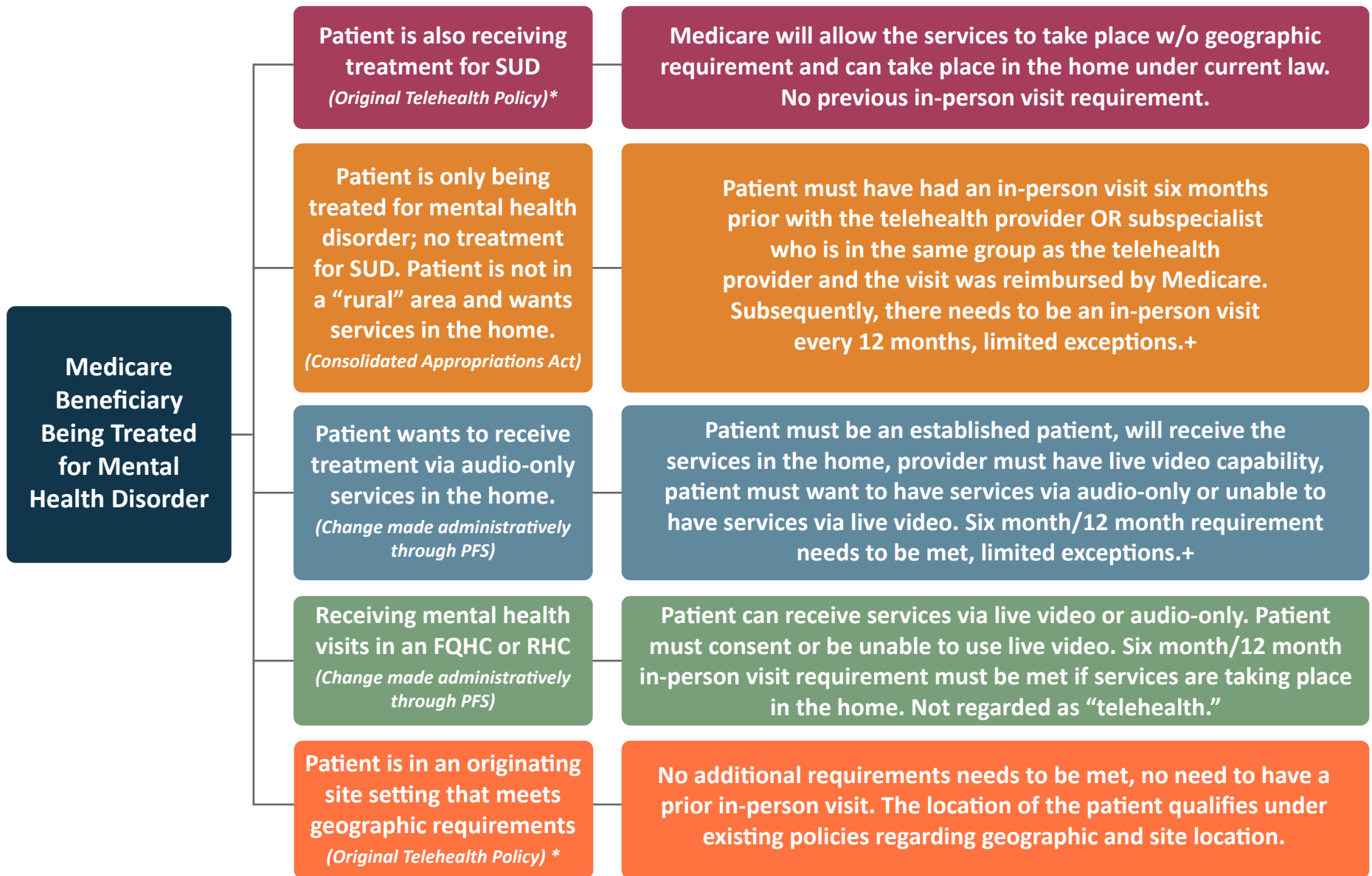
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CY 2022 MEDICARE REIMBURSEMENT FOR MENTAL HEALTH SERVICES VIA TELEHEALTH & AUDIO-ONLY



* Original Telehealth Policy refers to the existing telehealth policy in federal statute that existed prior to the Consolidated Appropriations Act.

+ Limited exceptions to the 12 month in-person visit include when the provider and patient agree the risks to patient's care outweighs the need for the in-person visit.